Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SOUTH TEXAS RADIOLOGY GROUP

Respondent Name
MITSUI SUMITOMO INSURANCE USA

MFDR Tracking Number
M4-11-3820-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 5, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "09/15/2010 We updated our system to bill our charge to Sumitomo Marine…01/06/2011 We contacted the Mitsui Sumitomo office in San Antonio."

Amount in Dispute: $9.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider asserts that it is excused from complying with Rule 133.20(b) because it meets the exception under section 408.0272(b), (c), or (d) of the Texas Labor Code…The carrier attaches a copy of the TXCOMP information concerning workers' compensation carriers with the name of 'Sumitomo Marine,' There is no such workers' compensation carrier with an address of P.O. Box 97035 Red or Redman, WA 98502. In fact the provider submitted no proof, other than its own representation and internal computer screens which reveal very little information, that the medical bill was, in fact, sent to 'Sumitomo Marine'….The provider also failed to submit documentation that Sumitomo Marine returned the medical bill to the provider because there was no coverage. There was no explanation as to why the provider contacted Mitsui Sumitomo's San Antonio office on January 6, 2011…Regardless of what prompted the provider to contact the carrier on January 6, 2011, the provider failed to meet the requirements under section 408.0272(b) by showing that it actually timely submitted its bill to a workers' compensation carrier. Therefore, the provider is not entitled to reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 27, 2010	CPT Code 73140-26 Finger X-ray	$9.80	$9.80

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. Texas Labor Code §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a

claim by a health care provider.

3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
4. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
5. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 29-The time limit for filing claim/bill has expired.
   - RM2-Time limit for filing claim has expired.
   - TX providers must bill within 95 days of date of service.

Issues

1. Were the services billed to a workers' compensation carrier timely?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed service based upon reason code "29."

   Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   Texas Labor Code §408.0272(b)(1) states "Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if: (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with: (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured; (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title."

   The disputed date of service is August 27, 2010. The requestor billed Sumitomo Marine Insurance on September 15, 2010 to an address in Redman, WA. On January 6, 2011, the requestor was notified that the requestor had billed the wrong Sumitomo Marine Insurance and filed with the Sumitomo Marine Insurance in San Antonio, TX. The Division finds that the requestor supported that they erroneously filed for reimbursement with a workers' compensation insurance carrier within 95 days per Section 408.0272(B)(1)(A).

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2010 DWC conversion factor for this service is 54.32.

   The Medicare Conversion Factor is 36.8729

Review of Box 32 on the CMS-1500 the services were rendered in San Antonio, Texas. Per Medicare the provider is reimbursed using the locality of "Rest of Texas".

The Medicare Participating amount for code 73140-26 is $6.92.

Using the above formula, the Division finds the MAR is $10.19; however, the requestor is seeking a lesser amount of $9.80. The respondent paid $0.00. As a result, the Division finds the requestor is due $9.80.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $9.80.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $9.80 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		08/14/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.